

# **EXHIBIT 1**

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF OHIO  
EASTERN DIVISION**

**IN RE: NATIONAL PRESCRIPTION OPIATE  
LITIGATION**

This document relates to:

*Jennifer Artz, et al. v. Endo Health Solutions Inc., et al.*  
Case No. 1:19-OP-45459

*Michelle Frost v. Endo Health Solutions Inc. et al.*  
Case No. 1:18-OP-46327

*Salmons v. Purdue Pharma L.P., et al.*  
Case No. 1:18-OP-45268

**MDL No. 2804**

**Case No. 17-md-2804**

**Judge Dan Aaron Polster**

**DEFENDANTS' SURREPLY IN OPPOSITION TO NAS PLAINTIFFS'  
MOTION FOR CLASS CERTIFICATION**

In their reply in support of their motion for class certification, Plaintiffs make several new factual and legal assertions. This surreply addresses just three of them:

- Plaintiffs offer yet another new class definition, requiring “(1) guardianship over (2) a child diagnosed with NAS (3) whose birth mother had a prescription for opioids prior to that birth, or alternatively and more narrowly, (4) a prescription during pregnancy,” Dkt. 3555 at 2-3;
- Plaintiffs belatedly offer a new declaration from their expert, Dr. Anand, allegedly reflecting Dr. Anand’s recent review of individual medical records, from which he now purports to opine that the children of the proposed class representatives suffered from NAS;
- Plaintiffs introduce a new request for the certification of an issue class (although without specifying the issues on which certification is sought).<sup>1</sup>

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<sup>1</sup> Plaintiffs also newly assert in their reply that their “conspiracy allegation is the centerpiece of this litigation.” Dkt. 3555 at 5. This argument fails for the reasons set out in Defendants’

It is black letter law that arguments raised for the first time in a reply brief are waived. *See Hunt v. Big Lots Stores, Inc.*, 244 F.R.D. 394, 397 (N.D. Ohio 2007) (collecting Sixth Circuit cases). Likewise, Rule 26, Rule 37(c), and the Court’s scheduling order all bar parties from submitting belated expert opinions in support of motion papers. *See, e.g., Hobart Corp. v. Dayton Power & Light Co.*, 2020 WL 5106743, at \*3-4 (S.D. Ohio Aug. 31, 2020); *Moonbeam Capital Investments, LLC v. Integrated Construction Solutions, Inc.*, 2020 WL 1502004, at \*6 (E.D. Mich. Mar. 30, 2020); *see also* Opinion & Order, Dkt. 2131, at 3-4 (striking expert affidavit when untimely disclosed in support of motion instead of on schedule set by Court). But even if the Court were to consider these new arguments and opinions, Plaintiffs still do not meet their burden to prove that their proposed class meets the requirements of Rule 23. *Halliburton Co. v. Erica P. John Fund, Inc.*, 573 U.S. 258, 275 (2014). Indeed, Plaintiffs’ shifting positions further underscore why this class should not be certified.

### **Plaintiffs’ New Class Definition**

Plaintiffs’ motion for class certification sets forth their proposed class and subclass definitions multiple times, and at length. *See* Dkt. 3066 at 1-2, 5, 10-12; Dkt. 3066-1 at 4-6; Dkt. 3066-2 at 1, 4, 7, 9-10. There were numerous contradictions and inconsistencies among those definitions, but in *every instance*, Plaintiffs explicitly described their proposed class as limited to guardians of children “medically diagnosed with ***opioid-related NAS at or near birth.***” *See id.* (emphases added). Plaintiffs have repeatedly stressed that the class they seek consists of

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Opposition. Allegations of conspiracy are insufficient for purposes of the Rule 23 factors to overcome the fact that the birth mothers of class members’ children consumed opioids that were manufactured, distributed, and dispensed by different Defendants. *See* Dkt. 3536 at 28-29, 39-40, 48 n.29, 52-53. Moreover, not all proposed class representatives have even *pled* conspiracy against all of the Defendants, under either federal or state law. *Id.* at 8, 40-41.

guardians of “infants born addicted to opioids from *in utero* exposure,” among other limitations. *See, e.g.*, Dkt. 3066 at 2 n.3. But in response to Defendants’ opposition, which demonstrated that the children of the proposed class representatives were not “medically diagnosed with opioid-related NAS” at birth, Plaintiffs bizarrely accuse Defendants of “improperly graft[ing] an additional requirement onto the class definition.” *Id.* at 3.

Recognizing that their class representatives do not satisfy their originally proposed class definitions, Plaintiffs now seek to abandon those definitions and switch to the new class definition quoted above. Significantly, their new proposed definition eliminates the requirement that the child’s NAS diagnosis have any connection whatsoever to the birth mother’s use of opioids — the reinvented definition presents the birth mother’s use of opioids and the child’s NAS diagnosis as two entirely siloed requirements. It also eliminates the requirement that the NAS diagnosis be “at or near birth,” thereby allowing belated purported diagnoses for litigation purposes. Furthermore, Plaintiffs have not stated whether they are abandoning the other components of their prior class definitions, including that the children in question be born after March 16, 2000; that the “opioids or opiates [be] manufactured, distributed, or filled by a Defendant or Purdue entity”; that children not have been “treated with opioids after birth, other than for pharmacological weaning”; and that the guardians not be political subdivisions. Dkt. 3066 at 1-2.<sup>2</sup>

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<sup>2</sup> Nor have Plaintiffs addressed how this new definition relates to the various proposed classes, subclasses, and state-specific classes set forth in their original motion.

Plaintiffs make no effort to explain how the requirements of Rule 23 could be satisfied if these significant limitations are removed.<sup>3</sup> In fact, Plaintiffs' proposed redefined classes would have *greater* challenges under Rule 23. For example, in their opening brief Plaintiffs argued that all proposed class members would satisfy the elements of medical monitoring claims, such as the level of substance exposure and increased risk as a result of that exposure, because any child meeting the class definition would have experienced and been diagnosed with NAS related to opioid exposure. *See* Dkt. 3066-1 at 20-21, 36-37. Even if this argument had merit (which it does not, as demonstrated in Defendants' opposition), Plaintiffs' new class definition would abandon it, as Plaintiffs' class would include guardians of children whose NAS diagnosis had nothing to do with opioid exposure. Plaintiffs' redefined class would even include the guardian of a child whose birth mother received an opioid prescription in her childhood, did not fill the prescription and never ingested an opioid, and years later had a child diagnosed with NAS related to her use of a *different* substance during pregnancy.<sup>4</sup> Accordingly, like the originally proposed class definition, the new class definition unquestionably requires individualized evidence to establish each element of a medical monitoring claim against Defendants. And the

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<sup>3</sup> For example, Plaintiffs fail to explain how a class member could possibly have a claim against these Defendants if the opioids consumed by the birth mother were not marketed, distributed, or dispensed by any of the Defendants, or if the pertinent events occurred so long ago that the statute of limitations necessarily bars recovery.

<sup>4</sup> Plaintiffs argue that NAS is a diagnosis that is made *only* as a result of *in utero* opioid exposure. Dkt. 3555 at 14-15. This argument is contrary to the overwhelming evidence presented by the experts in this case, including the admission of Plaintiffs' expert Dr. Anand that infants can receive scores on the Finnegan diagnostic scale that lead to an NAS diagnosis without being exposed to opioids *in utero*. Ex. A, Anand Deposition at 266:12-269:18. Dr. Anand also admits that other drugs can cause abstinence syndromes in neonates and that the characteristics of those other abstinence syndromes and abstinence syndrome caused by opioids overlap. *Id.* at 77:13-78:3. And whether any particular infant was correctly diagnosed with NAS or whether that infant's symptoms were caused by another substance would still require case-by-case examination. *See* Dkt. 3523-3, Rubin Report, at 2.

necessity of that individualized evidence precludes findings of typicality, commonality, or adequacy under Rule 23(a), and findings of predominance and superiority or cohesion under Rule 23(b). *See* Dkt. 3536 at 27-35, 46, 56, 58-59.

**The “Supplemental” Declaration of Plaintiffs’ Expert Dr. Anand**

Plaintiffs offer in support of their reply a new “supplemental” declaration from their expert, Dr. Anand, in which he asserts that Melissa Barnwell, Jacqueline Ramirez, and Ashley Poe “meet the class definition of clients with children suffering from NAS.” Anand Supplemental Decl., Dkt. 3557, at 2. Dr. Anand bases this assertion on a chart in which he assesses whether each child met factors including a “positive” “maternal history” and “medication assisted therapy.” *See id.*

As an initial matter, the declaration is procedurally barred because it is nearly a year late. As required by this Court’s scheduling order, Plaintiffs disclosed their expert reports in support of class certification in December 2019. Dkts. 2738, 2969. Defendants deposed Dr. Anand on January 28, 2020. At that time, Dr. Anand had not reviewed *any* records related to individual proposed class representatives and had not relied on them in reaching his opinion. He testified that the materials served on Defendants before his deposition contained a “complete statement” of his opinions and that he had identified all of the materials on which he intended to rely.<sup>5</sup> Ex.

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<sup>5</sup> In this regard, Plaintiffs’ assertion that Defendants have not challenged the methodology of Plaintiffs’ experts falls flat. Dkt. 3555 at 21-22. First, Defendants could not have challenged these new opinions of Dr. Anand before now. Second, insofar as Plaintiffs’ experts’ opinions relate to class certification at all — and most of them do not — they support Defendants in acknowledging the variation between individuals that bars class treatment. Defendants reserve the right to challenge the admissibility of these opinions as to the *merits* of Plaintiffs’ claims at the appropriate time.

A, Anand Deposition at 55:23-56:17, 59:3-11. In short, Dr. Anand's tardy supplemental declaration is foreclosed by the scheduling order and Dr. Anand's own testimony.

Moreover, while styled as "supplemental," Dr. Anand's new declaration offers wholly new opinions based on the review of medical evidence Dr. Anand did not previously consider. Plaintiffs never sought leave to supplement Dr. Anand's opinions or otherwise indicated that they would offer him as an expert on the individual medical conditions of each class representative's child. Defendants have had no opportunity to test through cross-examination the accuracy and basis of Dr. Anand's new opinions (much less to offer responsive opinions from their own experts). Moreover, Dr. Anand's declaration fails to identify the basis of these new opinions: It offers no citations to specific medical records and assesses the children on criteria different from those set forth in his prior declaration (which did not include "maternal history" or "medication assisted therapy" criteria). *Compare* Dkt. 3557 at 2 *with* Dkt. 3067-5 at 134. Accordingly, the Court should disregard this untimely filing.

Even if the Court considers Dr. Anand's new report, the opinions set forth in the report fail to demonstrate that the proposed class representatives are members of the class. Neither the criteria set forth in Dr. Anand's initial report nor those reflected in his supplemental report satisfy Plaintiffs' originally proffered class requirement that the children have been "medically diagnosed with opioid-related NAS at or near birth." *See* Dkt. 3536 at 8-9, 21. Nor do they satisfy Plaintiffs' new class requirement that the children simply be "diagnosed" with NAS. And Dr. Anand's proffered *conclusion* about each child ("suffering from NAS") also does not match any of Plaintiffs' varying class definitions. In fact, Dr. Anand's supplemental declaration explicitly admits that the medical records for the child of Jacqueline and Roman Ramirez do *not* contain an NAS diagnosis, although Dr. Anand still claims that the child was "suffering from

NAS.” Dkt. 3557 at 2. Accordingly, Dr. Anand’s new opinions do not render any of these guardians members of either the original proposed class or the new proposed class.

Even more significantly, Plaintiffs’ reliance on expert testimony to purportedly establish that specific children could have been diagnosed as having NAS — by asking Dr. Anand to apply “the published medical literature [and] [his] knowledge, training and clinical experience” to the children’s medical records — *proves* that these cases are unsuitable for class treatment. Class membership must be objectively defined and may not require “individualized fact-finding.” *Romberio v. Unumprovident Corp.*, 385 F. App’x 423, 431 (6th Cir. 2009). Dr. Anand’s need to review and evaluate hundreds of pages of individual medical records is a prime example of individualized fact-finding.

#### **Plaintiffs’ Request for Issue Class Certification**

Despite having filed multiple amended complaints and a motion for class certification nearly a year ago, Plaintiffs ask for an issue class to be certified for the first time in their reply. Dkt. 3555 at 40. While Rule 23(c)(4) permits an action “[w]hen appropriate” to be “brought or maintained as a class action with respect to *particular issues*” (emphasis added), Plaintiffs do not identify in their class definitions (or otherwise) any “particular issues” for which they seek certification; nor do they demonstrate how any such issues satisfy the Rule 23 requirements. Instead, they merely purport to cite “example[s]” of issues that they assert “can be resolved once for all class members on the basis of common evidence.” *Id.* This falls far short of satisfying their burden under Rule 23. To support certification of an issue class, Plaintiffs must prove that the selected “particular issue” meets all of the requirements under Rule 23(a) and (b). *See In re Nat’l Prescription Opiate Litig.*, 976 F.3d 664, 775 (6th Cir. 2020); *see also Martin v. Behr Dayton Thermal Prods. LLC*, 896 F.3d 405, 413 (6th Cir. 2018) (requiring predominance and

superiority requirements to be met for issue class). Plaintiffs have made no such showing in the single, conclusory paragraph they devote to this issue.

Moreover, Plaintiffs' "example" issues, unlike those certified in *Martin*, are demonstrably not "questions that need only be answered once because the answers apply in the same way" to each plaintiff. *Martin*, 896 F.3d at 415. For example, Plaintiffs suggest as a possible "issue" for class treatment "the *potential* of exposure to opioids *in utero* to cause harm." Dkt. 3555 at 40 (emphasis added). But that issue cannot be resolved on a class-wide basis. Plaintiffs' own expert Dr. Howard admitted that the potential of opioids to cause particular harms to a fetus varies by factors including the type of harm, the timing of exposure, the duration of exposure, and the genetics and medical history of the mother and father. *See, e.g.*, Howard Deposition, Dkt. 3523-7, at 44:3-45:5, 181:11-182:18, 397:2-18. The potential of exposure to opioids *in utero* to cause harm, therefore, is a question that must be examined for each plaintiff with respect to the opioids involved with that plaintiff's case, the times and quantities in which they were taken, and the particular harms alleged. And even were Plaintiffs to establish that their children's exposure to opioids *in utero* could cause them harm, such a conclusion would prove nothing as to any other, let alone every other, absent class member.

### CONCLUSION

Plaintiffs' ongoing revisions to their class definition, supporting evidence, and rationale and continued inability to satisfy the requirements of Rule 23 demonstrate that their claims are fundamentally unsuitable for treatment as a class action. For the reasons set forth in Defendants' opposition to class certification and in the foregoing, Plaintiffs' motion for class certification should be denied.

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UNITED STATES DISTRICT COURT  
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**IN RE: NATIONAL PRESCRIPTION  
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**MDL No. 2804**

**Case No. 17-md-2804**

**Judge Dan Aaron Polster**

**DECLARATION OF EMILY ULLMAN IN SUPPORT OF DEFENDANTS' SURREPLY  
IN OPPOSITION TO NAS PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

I, Emily Ullman, declare as follows pursuant to 28 U.S.C. § 1746:

1. I am an attorney at the law firm of Covington & Burling LLP, counsel for Defendant McKesson Corporation. I am a member in good standing of the bars of the State of New York and the District of Columbia. I have personal knowledge of the facts set forth in this Declaration, which I make to place before the Court documents and information relevant to its determination of Defendants' Opposition to NAS Plaintiffs' Motion for Class Certification.
2. Attached hereto as **Exhibit A** is a true and accurate copy of excerpts from the deposition transcript of Dr. Kanwaljeet Anand, dated January 28, 2020.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

/s/ Emily S. Ullman  
Emily S. Ullman

# **Exhibit A**

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF OHIO  
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VIDEOTAPED DEPOSITION OF  
DR. KANWALJEET ANAND, M.D.

January 28, 2020

Chicago, Illinois

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22

23 ALSO PRESENT:

24 Mr. Kevin Duncan, Videographer

\* \* \*

1 until you get there.

2 A. Yes.

3 Q. And it has an execution date of  
4 December 8, 2019, correct?

5 A. That is correct.

6 Q. Is this document a significant work  
7 product you submitted in this litigation in  
8 December of 2019?

9 A. That is correct.

10 Q. When submitting this declaration,  
11 did you have an understanding of what were the  
12 requirements, not the subject matter but the  
13 requirements of what goes in -- into the  
14 declaration?

15 A. Yes, I did.

16 Q. Okay. What were your understandings  
17 of those requirements?

18 A. My understanding was that this  
19 declaration was requested in order to define a  
20 class of individuals that had been damaged due  
21 to opioid exposure during their prenatal period  
22 through use by the mother, by the birth mother.

23 Q. Is this declaration intended to be a  
24 complete statement of all the opinions you

1 intend to express related to NAS as risk  
2 factors and as long-term consequences?

3 A. That is correct.

4 Q. And -- I apologize, go ahead.

5 A. I'd just like to direct your  
6 attention to the last paragraph of this  
7 declaration saying that:

8 With the Court's permission, I would  
9 like to reserve the right to update this report  
10 in order to reflect the accumulating scientific  
11 and medical evidence as necessary.

12 Q. I appreciate the clarification,  
13 Doctor.

14 At the time you submitted this  
15 declaration, was it intended to be complete as  
16 of that point in time?

17 A. Yes, it is.

18 Q. Do you have opinions you have formed  
19 but chosen about NAS, its risk factors and it's  
20 long-term consequences, that you have chosen  
21 not to include in this declaration?

22 A. No. For the most part, this is an  
23 accurate summary of my opinions.

24 Q. And let me ask the question slightly

1 differently:

2 Are there any opinions you've  
3 already formed and intend to provide that you  
4 chose not to include in this declaration?

5 A. I have reviewed additional evidence  
6 that I became aware of and provided that  
7 evidence as of January 24th, so other than its  
8 relationship to the content of this  
9 declaration, there was, you know, perhaps minor  
10 changes, mostly semantic or of a minor nature  
11 that may have occurred in the light of that new  
12 evidence.

13 Q. The January 24, 2020, submission  
14 that you're speaking of had substance additions  
15 from your December 2019 declaration?

16 A. So the declaration itself has not  
17 been changed, but the additional evidence that  
18 I have reviewed may have affected my opinions  
19 to a minor degree.

20 Q. Have you thought about whether or  
21 not -- strike that.

22 Let me ask the question differently:

23 Have you thought about how the  
24 additional evidence in 2020 has impacted any

1 specific opinions you've given in your  
2 December 2019 declaration?

3 A. As I stated, this was probably of a  
4 minor nature, simply confirming or adding  
5 additional references, which was  
6 related -- which is reported in those five  
7 documents that I had e-mailed to counsel on the  
8 24th.

9 MR. BILEK: And for the record, I  
10 e-mailed them to Emily that day.

11 MR. EHSAN: Understood.

12 BY MR. EHSAN:

13 Q. I'm not suggesting that you did not  
14 provide additional literature but my question  
15 was simply:

16 To the extent you know that those  
17 five articles have changed any of your  
18 opinions, sitting here today, can you  
19 articulate that? Or you may not know how it's  
20 changed any of your opinions. I'm just asking  
21 that question more generally.

22 A. Yeah, so, in general, like I said,  
23 there has been no substantial change in my  
24 opinions. Some of those opinions have been

1 validated and confirmed by the accumulating  
2 data.

3 Q. To the extent that you have  
4 references in this declaration and you provided  
5 some additional supporting material, does that  
6 collective body of citations represent a  
7 complete list of all the external, meaning not  
8 in your head from your training, information  
9 you intend to rely on in supporting the  
10 opinions you provide?

11 A. That is correct.

12 Q. Did you consider any facts or data  
13 outside what's listed in your declaration in  
14 forming your opinions?

15 A. Other than what's listed in the  
16 references of this document, I relied on my  
17 clinical experience.

18 Q. You didn't perform any data analysis  
19 that's not identified in this declaration; is  
20 that correct?

21 A. That is correct.

22 Q. Did you provide -- let me strike  
23 that.

24 In connection with preparing your

\* \* \*

1 neonatal opioid withdrawal syndrome are terms  
2 used to denote a group of problems that occur  
3 in children who are exposed to opioids or  
4 opiate drugs in the mother's womb.

5 Do you see that?

6 A. Yes.

7 Q. What is your understanding of the  
8 distinction between NAS and NOWS?

9 A. They're essentially the same thing.  
10 There are -- they describe a clinical diagnosis  
11 manifesting the signs and symptoms of opiate  
12 withdrawal.

13 Q. Are opioids the only class of  
14 medication that can cause an abstinence  
15 syndrome in a child?

16 A. No, there are other classes of drugs  
17 that can cause an abstinence syndrome.

18 Q. And those abstinence syndromes,  
19 would they present in a clinically unique way  
20 that's distinguishable from opioid withdrawal  
21 syndrome in a neonate?

22 A. Yes, to a great extent, they would.

23 Q. Are there any other characteristics  
24 that overlap between abstinence syndrome from

1     opioids and abstinence syndrome from some other  
2     drug of abuse?

3             A.       There may be some overlap.

4             Q.       So just because a neonate is  
5     diagnosed with NAS doesn't necessarily mean the  
6     birth mother had mild, moderate or severe OUD,  
7     correct?

8             A.       So the birth mother may not have an  
9     opioid use disorder, may have been prescribed  
10    opiates for a particular condition, which then  
11    exposed the fetus to significant levels and  
12    durations of opiates and resulted in NAS  
13    manifesting after birth.

14            Q.       The diagnostic approach to a neonate  
15    and whether or not that neonate has NAS is  
16    distinct from the diagnostic approach to the  
17    mother and whether the mother has OUD, correct?

18            A.       That is correct.

19            Q.       Do you have, sitting here today, an  
20    opinion as to what the minimum exposure would  
21    be necessary to cause a neonate to undergo an  
22    abstinence syndrome from the maternal exposure  
23    to an opioid?

24            A.       There is no minimum exposure.

\* \* \*

1           Q.       Now, you mentioned this is a  
2       clinical diagnosis.

3                   Do you -- is that to distinguish it  
4       from a laboratory diagnosis or a radiological  
5       diagnosis?

6           A.       That is correct.

7           Q.       So, for example, in diabetes, if you  
8       have two hemoglobin A1Cs greater than 6 1/2 and  
9       3 months apart that would be sufficient to make  
10      the diagnosis of diabetes, correct?

11          A.       That is correct.

12          Q.       And here, you want 8 numbers on here  
13      or a total score of 8, at least four hours  
14      apart though we are not sure how -- what the  
15      other end of the spectrum is, correct?

16          A.       That is correct.

17          Q.       You have to get the 8 points the  
18      same way, i.e., do you have to check off the  
19      same boxes in that 4-hour interval?

20          A.       No, no. The way this is set up  
21      is -- is you reach a score of 8 because the  
22      pattern of NAS changes as time goes on.

23          Q.       So you may, at Time Interval 1, you  
24      may score 8, let's say with just a GI -- well,

1     yeah, you get to just a GI stuff. You could  
2     score an 8 just for the GI stuff, GI  
3     symptomatology, and on Time Interval 2, you  
4     could score 8 for the central nervous system  
5     disturbances?

6             A.     Yeah.

7             Q.     Now, I'm just going to specifically  
8     ask about a couple of these. Here's a -- the  
9     first one is high-pitched cry.

10            Do you see that?

11            A.     Yes, I do.

12            Q.     Is that specific to opioid  
13     withdrawal?

14            A.     It is indicative. It's not  
15     pathognomonic. It's not -- you can get a  
16     high-pitched cry from, say, other conditions,  
17     like there's a Cri du chat syndrome, which is a  
18     genetic disorder which has a high-pitched cry,  
19     or there are other conditions that lead to a  
20     high-pitched cry.

21            Q.     Sleeping less than an hour after  
22     feeding, is that specific to opioid withdrawal?

23            A.     No, it's not specific to opioid  
24     withdrawal.

1 Q. How about sleeping less than two  
2 hours after feeding?

3 A. Not specific either.

4 Q. How about sleeping greater than  
5 three hours after feeding?

6 A. That is not specific either.

7 Q. Fever of -- so going down to the  
8 next section, Metabolic Disturbances, fever of  
9 37 point -- or 38.3, is that something you  
10 can -- a child can have without being exposed  
11 to opioids?

12 A. Yes, they can.

13 Q. Fever greater than 38.4?

14 A. Yes.

15 Q. How about nasal stuffiness?

16 A. Yes, they can have that from some  
17 other cause.

18 Q. Can a child sneeze greater than  
19 three to four times without having been exposed  
20 to opioids?

21 A. Yes, they can.

22 Q. How about -- how about nasal  
23 flaring?

24 A. They can have nasal flaring from

1 other causes.

2 Q. There's in fact a series of diseases  
3 that a mother can pass on to a child that are  
4 pneumonically called the TORCH syndromes,  
5 correct?

6 A. That is correct.

7 Q. And some of those TORCH syndromes  
8 could also cause some of the symptoms that are  
9 described here, correct?

10 A. That is correct.

11 Q. So is it possible for a child  
12 without any opioid exposure, by just having the  
13 right combination of symptoms, and putting  
14 aside the likelihood of whether that occurs or  
15 not, but is it possible for a child to hit  
16 8 points on this scale without ever having been  
17 exposed to opioids?

18 A. It is possible, yes.

19 MR. EHSAN: So I don't have any more  
20 questions for you, Doctor. I appreciate  
21 your time and your patience with me today.  
22 I will only say that -- that I've been told  
23 that we are going to get a copy of your --  
24 an additional publication that was from

\* \* \*

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